PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 9/6/2024
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**

Drug Name (specify drug) _____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1. What is the diagnosis?
   - Primary hypogonadism (If checked, go to 2) ☐
   - Hypogonadotropic hypogonadism (If checked, go to 2) ☐
   - Age-related hypogonadism (If checked, no further questions) ☐
   - Late-onset hypogonadism (If checked, no further questions) ☐
   - Gender dysphoria (If checked, go to 9) ☐
   - Other, please specify. (If checked, no further questions) ☐

     _____

2. What is the patient's gender?
   - Biological male or a person that self identifies as male (If checked, go to 3) ☐
   - Female (If checked, no further questions) ☐

3. What is the patient's age?
   - 18 years of age or older (If checked, go to 4) ☐
   - Less than 18 years of age (If checked, no further questions) ☐

4. Is the request for continuation of therapy? **Y** ☐ **N** ☐

5. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
   - Yes (If checked, go to 7) ☐
   - No (If checked, go to 6) ☐
   - Unknown (If checked, go to 7) ☐

6. Before the start of therapy, did the patient have at least two confirmed low morning serum total testosterone concentrations based on reference laboratory range or current practice guidelines? **Y** ☐ **N** ☐

7. Prior to initiating therapy with the requested drug, did the patient have at least two confirmed (pre-treatment) low morning serum total testosterone concentrations based on reference laboratory range or current practice guidelines? ACTION REQUIRED: If Yes, attach copy of laboratory report with pretreatment morning serum total testosterone concentrations.

- Yes (If checked, go to 8) ☐
- No (If checked, no further questions) ☐
- Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

8.	Is the copy of the laboratory report with pretreatment morning serum total testosterone concentrations attached to this request?	**Y** ☐	**N** ☐
9.	Is the patient less than 18 years of age?	**Y** ☐	**N** ☐
10.	Are the patient's comorbid conditions reasonably controlled?	**Y** ☐	**N** ☐
11.	Is the patient able to make an informed decision to engage in hormone therapy?	**Y** ☐	**N** ☐
12.	Has the patient been educated on any contraindications and side effects to therapy?	**Y** ☐	**N** ☐
13.	Is the request for continuation of therapy?	**Y** ☐	**N** ☐
14.	Has the patient been informed of fertility preservation options?	**Y** ☐	**N** ☐
15.	Has the patient been informed of fertility preservation options before the start of therapy?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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Prescriber (Or Authorized) Signature and Date